

Attachment 6b

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION
REQUEST FORM

PA/RF

(DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1. PROCESSING TYPE

112

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER 1234567890		4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE) I.M. Nursing Home 609 Willow Anytown, WI 53725	
3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL) Recipient, Im A.		7 BILLING PROVIDER TELEPHONE NO (XXX) XXX-XXXX	
5 DATE OF BIRTH MM/DD/YY	6 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>	8 BILLING PROVIDER NO 12345678	
6 BILLING PROVIDER NAME, ADDRESS, ZIP CODE I. M. Provider 1 W. Williams Anytown, WI 53725		10 DX PRIMARY 720 Rheumatoid Spondylitis	
		11 DX SECONDARY 345.1 Epilepsy	
		12 START DATE OF SOI N/A	13 FIRST DATE RX N/A

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W9523		8	9	Range of Motion, Strengthening	1	XX.XX
W9529		8	9	Activities of Daily Living	1	XX.XX

An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

TOTAL CHARGE ²¹ XX.XX

22 MM/DD/YY DATE 23 I. M. PROVIDER I. M. Provider REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED QUANTITY AUTHORIZED

DATE

CONSULTANT/ANALYST SIGNATURE